STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, *Governor*

DEPARTMENT OF HEALTH SERVICES
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October 27, 2000

TO: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons
All County Public Health Directors
All County Mental Health Directors

Letter No.: 00-54

CERTAIN MEDICARE+CHOICE ORGANIZATIONS WITHDRAWAL AS MEDICARE HEALTH MAINTENANCE ORGANIZATION (HMO) PROVIDERS

The purpose of this letter is to inform county staff that effective January 1, 2001, certain Medicare+Choice Organizations throughout California will no longer be providing Medicare HMO coverage to beneficiaries. This may result in an increase in telephone inquiries and traffic in the local county welfare offices with questions regarding Medicare HMO providers and possibly incorrect coding on the Beneficiary Identification Card (BIC).

The Medicare+Choice plans will notify their enrollees of this no later than October 2, 2000, and will provide a listing of ongoing participating Medicare+Choice providers in their area. The plans are obligated to provide coverage to their beneficiaries through December 31, 2000. The enclosed Medicare Fact Sheet provides information on the protection of Medicare beneficiaries after Medicare+Choice Organization withdrawal and a question, and answer section that addresses basic beneficiaries' questions. The fact sheet also provides the Medicare toll free telephone number that individuals may call for more information and help in choosing another Medicare+Choice plan or fee-for-service Medicare.

Please provide staff with a copy of the enclosed Medicare Fact Sheet and advise them to refer beneficiaries with questions regarding the withdrawal of the Medicare+Choice plans to the Medicare toll-free telephone number at 1-800-MEDICARE. Direct county staff with questions regarding other health coverage coding problems to call the Medi-Cal toll-free Wide Area Telephone System at 1-800-952-5294.

Please direct questions regarding this letter to Vicki Partington of my staff at (916) 654-5909 or E-Mail Vparting@dhs.gov.ca.

Sincerely,

ORIGINAL SIGNED BY

Glenda Arellano, Acting Chief
Medical Eligibility Branch

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

Press Office
Washington, DC 20201

MEDICARE FACT SHEET

June 2000

Contact: HCFA Press Office
(202) 690-6145

PROTECTING MEDICARE BENEFICIARIES AFTER MEDICARE+CHOICE ORGANIZATIONS WITHDRAW

Background: *While more than nearly 39 million Americans in Medicare currently receive care through original fee-for-service Medicare, Medicare managed health care options have been available to some Medicare beneficiaries since 1982. About 70 percent of seniors and disabled people covered by Medicare are in areas served by at least one managed care plan. Only about 6.2 million, or 16 percent, currently have chosen to enroll in a Medicare HMO. Since 1998, most HMO contracts with the federal Health Care Financing Administration (HFCA) have operated under the Medicare+Choice program to provide health care coverage for beneficiaries in certain areas. The Medicare+Choice program was created by Congress in the Balanced Budget Act of 1997.*

Medicare+Choice organizations that decide not to continue serving beneficiaries in selected counties or entire service areas must notify HCFA six months earlier, or by July 1, that they will not renew their existing contracts.

In 1999, 41 Medicare+Choice organizations chose not to renew their Medicare+Choice contracts and 58 reduced their service areas for the year 2000. As a result of those business decisions, more than 327,000 Medicare beneficiaries were affected and about 79,000 – approximately 1.3 percent of the number of Medicare beneficiaries enrolled in Medicare+Choice – were left with no Medicare managed care options.

A year earlier, in 1998, plan nonrenewals and service area reductions affected approximately 407,000 Medicare beneficiaries enrolled in managed care plans and of those, approximately 47,000 had no other managed care options.

As private sector managed care companies continue to make market decisions that affect Medicare beneficiaries, HCFA is continuing to do all that it can to ease the transition for affected beneficiaries.

HCFA Works With Beneficiaries When Medicare+Choice Organizations Withdraw

Through the approximately $150 million National Medicare Education Program, *Medicare & You*, HCFA has been working with public and private partners that represent tens of millions of older and disabled Americans to provide information to beneficiaries about their rights and options. A key piece of this information is that beneficiaries are automatically eligible to return to original fee-for-service Medicare and that they have guaranteed access to some Medigap policies that help fill coverage gaps if their Medicare+Choice organizations leave the program.

Beneficiaries in every community can get the most up-to-date information from HCFA on available coverage options. This fall, HCFA will add new information about health plan options in the year 2001 to already available information at 1-800-MEDICARE (1-800-633-4227), HCFA's Medicare Choices Helpline. HCFA will also post new information about plan withdrawals on Medicare's consumer Internet site, www.medicare.gov.

Key partners include the Leadership Council of Aging Organizations, the American Association of Health Plans, AARP, the National Council of Senior Citizens, the National Rural Health Association, the National Committee to Preserve Social Security and Medicare, the National Council on Aging, the National Hispanic Council on Aging, the National Caucus and Center on Black Aged and the Older Women's League, as well as the Social Security Administration, HCFA regional offices, the U.S. Administration on Aging and State Health Insurance Assistance Programs.

Beneficiaries May Have Options in Areas Where Medicare+Choice Organizations Have Not Renewed

HCFA wants to make sure that beneficiaries know their options and continue to have access to health care. Plans that are not renewing their contracts for the 2001 contract year will continue to provide services to their Medicare enrollees through December 31, 2000. These plans are required to send all affected beneficiaries an information package by October 2, 2000 that explains beneficiaries' options to return to original fee-for-service Medicare or enroll in another Medicare+Choice organization, if one is available. All beneficiaries have the option of returning to original fee-for-service Medicare and may also have rights to supplemental coverage if they desire. Beneficiaries also have the option of enrolling in another Medicare+Choice organization if one is available.

HCFA reviews and approves all materials sent by plans to beneficiaries. HCFA also will remind plans of their responsibility to notify beneficiaries and provide plans with a model letter to do so. Most current enrollees can remain in their Medicare HMO through December 31, 2000, or they can disenroll before that time and either return to original fee-for-service Medicare or enroll in another Medicare+Choice organization, if one is available. If they take no action, they will automatically return to original fee-for-service Medicare on January 1, 2001. Beneficiaries may call 1-800-MEDICARE (1-800-633-4227) for assistance in making the right individual health care option decision.

HCFA Encourages Plans to Enter Markets Left Without a Medicare+Choice Option

HCFA will expedite review and approval of Medicare+Choice organizations seeking to enter markets that have been left without a Medicare+Choice option or any alternatives to original fee-for-service Medicare. HCFA will give these applications first priority for review, and will help plans enter these areas quickly -- as long as they meet quality and other standards that protect beneficiaries. In addition, the Balanced Budget Refinement Act of 1999 provides for bonus

payments to these plans. HCFA has begun the process necessary to pay these bonus payments to plans that meet the criteria outlined in the law.

Beneficiaries May Be Able to Choose Another Medicare+Choice Option

Other Medicare managed care plans and private fee-for-service plans that operate in the same area as a nonrenewing plan are required to be open to accept new enrollments during a Special Election Period, October 1 through December 31. Beneficiaries can choose an effective date of November 1, December 1 or January 1, as long as the plan receives the completed election form before the effective date.

Beneficiaries who enroll in another Medicare managed care plan, if one is available, or a private fee-for-service plan do not need to submit a disenrollment form.

Some beneficiaries living in certain states across the country may choose to enroll in a private fee-for-service plan. These plans may help beneficiaries with their deductibles and other out-of-pocket costs while providing for some extended benefits.

Returning to Original Fee-For-Service Medicare

Beneficiaries who wish to return to original fee-for-service Medicare should make sure that they consider their need for supplemental insurance coverage before they disenroll. The best decision for each beneficiary will vary based on their individual needs. However, if beneficiaries choose to disenroll and return to original fee-for-service Medicare before January 1, 2001, they can complete a disenrollment form available from their plan, a Social Security Administration (SSA) office, Railroad Retirement Board (RRB) office if they are railroad retirees, or the Medicare Choices Helpline – 1-800-MEDICARE (1-800-633-4227). The beneficiary's disenrollment will be effective the first day of the month following the month in which the plan, SSA or RRB receives the form. Beneficiaries who do not file a disenrollment form will automatically be enrolled in the original fee-for-service Medicare plan effective January 1, 2001.

Supplemental Insurance Through Medigap

Congress enacted legislation in 1999 that added a new time period where beneficiaries have access to Medigap policies when a plan leaves Medicare. Beneficiaries will continue to have

certain rights and protections when purchasing Medigap policies. As long as a beneficiary applies for a Medigap policy no later than 63 days after the coverage with the non-renewing HMO expires (December 31, 2000), the beneficiary is guaranteed the right to buy any Medigap policy designated "A", "B," "C," or "F" that is available in the state. If the beneficiary applies for one of these Medigap policies no later than March 4, 2001, companies selling these policies cannot place conditions on the policy (such as an exclusion of benefits based on a pre-existing condition) or discriminate in the price of the policy because of health status, claims experience, receipt of health care or medical condition.

Under the new legislation, beginning this year beneficiaries in Medicare+Choice plans who want to switch to original fee-for-service Medicare may do so as soon as they receive their final notice from their Medicare+Choice plans. If they choose this option, beneficiaries have 63 days from the date of the notice (from October 2, 2000 until December 4, 2000) to apply for a Medigap policy and be guaranteed the same protections they would have if they waited until their coverage expired on December 31, 2000. To exercise this option, beneficiaries must disenroll from their Medicare+Choice plan in October or November, and arrange for their Medigap policy to start the first day of the next month so they will have seamless coverage between the plans they choose.

CAUTION: Individuals must keep a copy of their HMO's termination letter to show a Medigap insurer as proof of loss of coverage under this HMO, whether they terminate their membership in October or November or wait until their coverage ends at the end of December. They should also keep a copy of their Medigap application to validate that they acted within 63 days of the final notice of termination.

If beneficiaries dropped a Medigap policy to join their current Medicare managed care plan and they have never enrolled in a similar health plan since starting Medicare, they are guaranteed the right to return to the Medigap policy they dropped if: the Medigap policy they dropped is still being sold by the same insurance company; they disenroll from their current health plan no later than 12 months after they initially enrolled in it (they do not have to wait until December 31, 2000); and they reapply for the policy they dropped no later than 63 days after they disenroll from their Medicare managed care plan.

In addition, beneficiaries who were new to Medicare at age 65 and chose to enroll in their Medicare+Choice plan during their initial election period, and are still in their first 12 months in the M+C plan, may choose <u>any</u> Medigap policy sold in the State, including those providing some outpatient prescription drug coverage. These individuals must voluntarily disenroll from the Medicare+Choice plan before the 12 months ends and apply for the Medigap policy within 63 days of their coverage ending.

Supplemental Coverage for Retirees Enrolled in an Employer-Sponsored Plan

Beneficiaries whose former employer has an arrangement with the Medicare+Choice organization offering the Medicare+Choice plan in which they are enrolled should consult with their employer before making changes.

Affected Beneficiaries May Be Able to Retain Their Doctors

Beneficiaries who choose to return to original fee-for-service Medicare will probably be able to continue to see the same physicians that they had seen through the HMO because most HMO physicians -- more than 90 percent -- also participate in original fee-for-service Medicare. If there are other Medicare+Choice organizations in the beneficiaries' geographic area, some of their current physicians may also participate with those Medicare+Choice plans.

Information on Other Medicare+Choice Plans

Up-to-date information about other Medicare+Choice plans available in a county is available at 1-800-MEDICARE (1-800-633-4227) and on the Medicare Compare page on www.medicare.gov. This information can be accessed by zip code, by county and by state. (Some Medicare+Choice plans are available only in certain counties within a state or zip code.) Many libraries and senior centers can help beneficiaries obtain information from this source.

General Assistance for Medicare Beneficiaries on Health Insurance Matters

Beneficiaries can contact their State Health Insurance Assistance Program for assistance. They can also contact the U.S. Administration on Aging's toll-free Elder Care Locator at 1-800-677-1116 to be referred to their local area agency on aging.

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Medicare Plan Choices

Managed Care Plan Withdraw Information - Frequently Asked Questions

Since the creation of Medicare+Choice (M+C) in 1997, the Health Care Financing Administration (HCFA) has been working continuously to ensure that there is a wide range of high-quality health care options available to Medicare beneficiaries and to improve the operation of M+C for the private companies that choose to serve them. Every year, managed care organizations make business decisions on whether they remain in the Medicare program. As a result of these decisions, some managed care organizations have decided not to renew their Medicare contracts in certain states and selected counties effective January 1, 2001.

The following questions are designed to help beneficiaries understand their M+C health care options if their plan is leaving the Medicare program.

Overview

1. I have heard that some Medicare managed care plans are leaving Medicare. How do I get information about whether this is true?

Yes, some managed care plans have decided to leave Medicare on January 1, 2001. If you have questions about your plan, you should contact them and ask if they will continue to be in Medicare in 2001. If your Medicare managed care plan is leaving the Medicare program, you may receive a letter this summer about your managed care plan's intent to withdraw from the Medicare program. This initial letter will be followed by a second letter that your managed care plan is required to send you no later than October 2, 2000. The October letter from your managed care plan will explain your rights and protections and will list other health plans that are available in your community.

Starting in mid-July, you can also call 1-800-MEDICARE (1-800-633-4227) for information about whether a managed care plan will continue to participate in the Medicare program. Individuals using a telephone device for the hearing impaired can call 1-877-486-2048 for assistance. At that time, HCFA will also post information about which managed care plans are leaving the Medicare program on Medicare's website at www.medicare.gov. Starting September 15, 2000, information about plan premiums and benefits for calendar year 2001 will be available through 1-800-MEDICARE and on **www.medicare.gov**.

2. What are my options if my managed care plan decides to leave Medicare in my area?

If your managed care plan ends its contract with the Medicare program January 1, 2001, you can:

1. stay in your managed care plan through December 31, 2000, and

   - return to the Original Medicare Plan, with or without a Medigap policy,
   - in another Medicare health plan effective on January 1, 2001;

2. leave your managed care plan before December 31, 2000 and

   - return to the Original Medicare Plan, with or without a Medigap policy,
   - if other Medicare health plans are available in your area, enroll in another health plan.

If there are other plans available in your area, they will be required to be open for enrollment in October, November and December, unless they already have as many members as they are able to serve. Under this "Special Election Period," you can choose an effective date of November 1, 2000, December 1, 2000 or January 1, 2001, as long as your enrollment form is submitted to the managed care plan before the effective date you request. You have until December 31 to enroll effective January 1.

You may also enroll in another plan earlier than October if the plan is accepting new enrollees. If a plan is accepting new enrollees in July, August, and September, you could enroll in the plan effective the first day of the next month, if you enroll by the 10th of the month. If you enroll after the 10th of the month, your effective date would be the first day of the second month following the month you made the election. For example, if you enrolled in another plan on July 9th, your enrollment would be effective August 1, 2000. If you enrolled on July 15th, your enrollment would be effective on September 1, 2000. Plans are not required to accept enrollees in August and September.

3. Will I immediately lose my coverage if my managed care plan decides to leave Medicare?

No. Unless you choose to leave your current managed care plan, you will continue to be covered by your managed care plan until December 31, 2000. If you stay in your current managed care plan through the end of the year, you must continue to use that plan's network of providers.

4. How will I know if there are other Medicare health plans for me to join if my managed care plan decides to leave Medicare?

Your current managed care plan will send you a letter no later than October 2, 2000, which will explain your rights and protections and will list any other Medicare managed care plans or Private Fee-for-Service plans available in your community. Starting in mid-July, you can also call 1-800-MEDICARE (1-800-633-4227) for information about what Medicare health plans will be available in your area in 2001. Individuals using a telephone device for the hearing impaired can call 1-877-486-2048 for assistance. This information will also be available on Medicare's website at **www.medicare.gov.** Starting September 15, 2000, information about plan premiums and benefits for calendar year 2001 will be available through 1-800-MEDICARE and on **www.medicare.gov**.

5. My Medicare managed care plan is leaving Medicare at the end of the year, how soon do I

need to make a decision about new health care coverage?

Even if your current managed care plan is leaving Medicare, it must provide services to you through the end of the year. It is your choice to remain enrolled in your managed care plan until December 31, 2000 or to leave earlier. It is important to carefully consider your alternatives. Changing the way you receive your health care is an important decision. You may wish to ask your family, friends, or doctor for help. In addition, State Health Insurance Assistance Program (SHIP) volunteers are available to discuss your individual situation and provide information on all options that are available to you. You can call 1-800-MEDICARE (1-800-633-4227) to get the telephone number of your local SHIP.

If you chose to return to the Original Medicare Plan and you wish to purchase a Medigap policy we recommend that you apply for Medigap early enough to have Medigap coverage begin at the same time you return to the Original Medicare Plan. This will either be on January 1, 2001, or whatever date your disenrollment is effective if you choose to disenroll before December 31, 2000. If you choose to disenroll during the "Special Election Period" in October, November, or December, you can choose an effective date of November 1, 2000, December 1, 2000, or January 1, 2001, as long as your disenrollment request is submitted before the effective date you choose. There are special Medigap protections for people who are in health plans leaving Medicare, but not all the same protections apply to everyone. (Refer to question #9 for more information on Medigap protections.)

6. Will I have the opportunity to join another Medicare health plan before January 1, 2001 if my managed care plan is leaving my area?

Yes if there are other Medicare health plans available in your community. While you may be able to enroll in another health plan at any time if they choose to be open to new enrollees (as stated in A2), these plans are required to accept new enrollees during a "Special Election Period" in October, November and December unless they already have as many members as they are able to serve. Under the rules of Special Election Period,

you can choose an effective date of November 1, 2000, December 1, 2000 or January 1, 2001, as long as your enrollment form is submitted to the health plan before the effective date you request. You have the option to remain in your current managed care plan through December 31, 2000.

All plans must be open to accept elections from all beneficiaries from November 1, 2000 through November 30, 2000 for a January 1, 2001 effective date.

Caution: Some managed care plans have approved limits on the number of beneficiaries they can enroll (called "capacity limits"). The approved limits on elections apply to both the Special Elections Period (October 1, 2000 through December 31, 2000) and the Annual Election Period (November 1, 2000 through November 30, 2000). If you would like to join a new managed care plan, you should contact the new managed care plan and ask whether they are accepting new elections. If a managed care plan refuses to accept your election, they must provide a written denial.

7. If I have Permanent Kidney Failure (ESRD), can I join another Medicare health plan?

If you have permanent kidney failure (ESRD) and your current managed care plan is leaving Medicare, you cannot enroll in a new managed care plan or private fee-for-service plan offered by another managed care company. However, you may enroll in another plan offered by your current managed care company, if one is available.

8. If I only have Medicare Part B, can I join another Medicare health plan?

You generally must be enrolled in Medicare Part A and Part B before you can enroll in a Medicare managed care plan or private fee-for-service plan. If you only have Medicare Part B and you want to join a new managed care plan or private fee-for-service plan, you will have to purchase Part A. You should call the Social Security Administration at 1-800-772-1213 or visit your local Social Security office if you want to enroll in Medicare Part A. The 2000 monthly premium for Part A

is $301 per month.

9. How can I receive additional assistance or more information about my health care options?

You can call 1-800-MEDICARE (1-800-633-4227), 8:00 a.m. to 4:30 p.m. local time. English and Spanish-speaking customer service representatives at this number can answer questions about the Original Medicare Plan and provide up-to-date information regarding the health plans available in your area.

You can also contact your State Health Insurance Assistance Program (SHIP). The telephone number for the SHIP in your State is available by calling 1-800-MEDICARE (1-800-633-4227). SHIP volunteers are available to discuss your individual situation and provide information on all options available to you.

Understanding Medigap

10. What is Medigap insurance?

A Medicare supplement policy, also known as Medigap insurance, is a private health insurance policy. It is designed to pay for certain expenses not covered by the Original Medicare Plan, also known as fee-for-service Medicare. Medigap policies typically provide coverage for some or all of the deductible, copayment and coinsurance amounts applicable to Medicare-covered services under the Original Medicare Plan, and sometimes cover items or services that are not covered by Medicare.

In most States, Medigap policies must conform to one of 10 standardized Medigap benefit packages that are labeled "A" through "J." Plan "A" contains certain basic benefits. Each of the other nine policies contains a different mix of additional benefits. Plan "J" contains the most comprehensive set of benefits.

Generally, it is not legal for anyone to sell you a Medigap policy while you are enrolled in any managed care plan or private fee-for-service plan. You may keep your Medigap policy if you join a managed care plan or

private fee-for-service plan, but you will not be able to use it for any Medicare covered services unless you return to the Original Medicare Plan. You may be able to use your Medigap policy for certain non-Medicare covered services, if your Medigap policy covers them. Generally, however, a Medigap policy will be of little use to you while you are in a managed care plan or private fee-for-service plan.

In addition to the questions and answers below, please call 1-800-MEDICARE (1-800-633-4227) and ask for a copy of the Guide to Health Insurance for People with Medicare. This guide gives information on buying a Medigap policy, using Medigap insurance and other kinds of health insurance, and your rights and protections. The guide is also available on the Internet at **www.medicare.gov**.

11. If I choose to return to the Original Medicare Plan, can I purchase a Medigap policy?

In most cases, yes. When a managed care plan leaves Medicare, you have certain rights but must apply for a Medigap policy within certain time frames. These rights apply to all beneficiaries over age 65. If you are under age 65, these rights apply to you to the extent that Medigap policies are made available in your State to beneficiaries under age 65.

These rights are sometimes referred to as "guaranteed issue" rights. This is a good name because it means that you are guaranteed the right to buy (or "be issued") a policy.

To get these rights, you must apply for a Medigap policy within:

- 63 calendar days from the date on your Final Notification Letter (which should be dated October 2, 2000); OR
- 63 calendar days after your managed care plan coverage ends on December 31, 2000.

If you voluntarily disenroll from your managed care plan before December 31, 2000, your 63-day guaranteed issue period will end 63 days after the date on your final notification letter, or December 4, 2000. If

you remain in your plan until you are automatically disenrolled on December 31, 2000, your 63-day guaranteed issue period will end on March 4, 2001.

CAUTION: If you disenroll any time before December 4, 2000, you will still only have until December 4 to apply for a Medigap policy. If you disenroll any time after December 4, but before coverage automatically ends on December 31, you will have **no Medigap protections**. You should consider your options carefully if you are considering disenrolling before December 31, 2000.

If you apply for a Medigap policy within one of these two guaranteed issue periods, the seller or insurer of that policy:

- Cannot deny you Medigap coverage or place conditions on the policy;
- Cannot charge you more for a policy because of past or present health problems; and
- Must cover you for all pre-existing conditions.

You must keep your copy of the Final Notification from your Medicare managed care plan (October 2, 2000 letter) and show it to the Medigap Insurer as proof of your guaranteed issue rights.

Further information is available from each State's Insurance Department or State Health Insurance Assistance Program (SHIP). The telephone number for the SHIP in your state is available by calling 1-800-MEDICARE (1-800-633-4227).

12. How soon will I need to make a decision about Medigap coverage?

The answer depends on your individual circumstances. Most beneficiaries should wait to make a decision until after they receive the Final Notification Letter from their managed care plan (which should be dated October 2, 2000). These beneficiaries then have 2 guaranteed issue periods to choose from, as described in Question # 11.

However, if you are getting your Medicare benefits in a managed care plan for the first time, and you enrolled

within the last year, you may want to act sooner. While you are still in the first 12 months of your first enrollment in managed care, you are entitled to broader choices of Medigap policies than are generally available to other beneficiaries who are being affected by their Medicare managed care plan withdrawals or service area reductions. (See Question #13)

CAUTION: If anyone who is NOT in their first 12-month period in managed care disenrolls and returns to the Original Medicare Plan before October 2, 2000, he/she will not have any guaranteed issue rights to purchase a Medigap policy.

13. What are the special circumstances under which I might want to apply for a Medigap policy sooner than waiting until October, November or December?

Two groups of beneficiaries in their first 12 months of managed care enrollment are entitled to broader Medigap protections than are generally available to other beneficiaries who are being disenrolled by their managed care plan:

1. People who were formerly in the Original Medicare Plan with a Medigap policy that they dropped when they joined a Medicare managed care plan for the first time and are within their first 12 months of enrollment in the plan.
2. People who joined a managed care plan as their first choice when they first became entitled to Medicare at age 65 and are within their first 12 months of enrollment in the plan.

People in these two groups are allowed an initial 12-month period in which to try out Medicare managed care. This period runs from the date of their "first time" enrollment in the Medicare managed care plan. Depending on the date they initially enrolled in a managed care plan, these beneficiaries may need to act quickly in order to take advantage of their extra rights. For instance, beneficiaries whose enrollment in the managed care plan began on August 1, 1999 would need to disenroll from their plan by July 31, 2000 in order to get these extra choices.

If you think you may be entitled to one of these 12-month periods, talk to your State Health Insurance Assistance Program. It is important that you not act on the assumption that you are entitled to these extra protections without getting expert help. **BUT if you are in this 12-month period, you must actively disenroll before your 12 month period ends and before you are automatically disenrolled on December 31, 2000 in order to exercise the broader choices that are available to you.**

Remember, however, if you are in one of these two groups and you stay in your plan until December 31, 2000, you will still have the same rights as others who will be disenrolled at that time.

14. What if I dropped a Medigap policy before I joined this Medicare managed care plan? Can I return to my old Medigap policy?

Maybe. If you are age 65 and over and you dropped your Medigap policy to join a Medicare managed care plan, you may be able to buy the same type of Medigap policy you had before IF:

A. The Medigap policy you dropped is still being sold by the same insurance company;

B. This is the first time you have ever been enrolled in any kind of Medicare managed care plan;

C. You leave (disenroll from) this managed care plan within 12 months of joining the plan; and

D. You apply for your previous policy no later than 63 days after coverage from your managed care plan terminates.

Before you disenroll from your managed care plan you should make sure the policy is still available from the original insurer. If the previous policy is no longer available, you are still guaranteed the right to buy a Medigap policy designated "A", "B", "C", or "F" that is offered by insurers in your State. You can use your right to return to your old Medigap policy any time during the first 12 months that you are enrolled in the

managed care plan.

NOTE: This right also applies if you are under age 65 to the extent policies are made available in your State to beneficiaries under 65.

15. What if I joined this managed care plan when I first turned 65 and I have been in it less than 6 months? Do I still have a Medigap open enrollment period?

During the first 6-months an individual is both 65 years of age or older and enrolled in Medicare Part B, the individual has what is called a Medigap open enrollment period. During this period, an insurer cannot: (1) refuse to sell you any of the 10 standardized Medigap policies that the insurer sells in the State, including the three called, "H," "I," and "J," which contain outpatient prescription drug coverage; (2) delay the issuance or effectiveness of the policy; or (3) discriminate in the pricing of such policy because of your health status, claims experience, receipt of health care, or medical condition.

If you became entitled to Medicare Part A at age 65 within the last 6 months, you may still have some time left in your Medigap open enrollment period which you could use. You did not lose it because you decided to enroll in a Medicare managed care plan when you first became entitled to Medicare Part B at age 65 or older.

16. Do I get any special protections because I never got to use my 6-month Medigap open enrollment period because I chose this HMO instead?

Even if your Medigap open enrollment period has passed or will expire very soon, you may be guaranteed the right to buy any Medigap policy (Plans "A" through "J"). These include the three plans that cover outpatient prescription drugs. You are guaranteed this right if you meet the following conditions:

- You enrolled in a Medicare managed care plan upon first becoming eligible for Medicare at age 65;
- You disenroll from your Medicare managed care

plan within 12 months of your original enrollment date in the managed care plan; and
- You apply for the Medigap policy of your choice within 63 days of the date your managed care plan coverage ends.

Additional Questions About the Medicare Program

17. Are all managed care plans leaving the Medicare program?

No, but some areas of the country will lose all managed care options on January 1, 2001.

18. Why are some managed care plans leaving the Medicare program?

Medicare managed care plans are private companies that make business decisions to contract or not contract with Medicare. Managed care plans voluntarily enter into 12-month contracts (January – December) with HCFA to serve Medicare enrollees. Each year, managed care plans have the opportunity to choose whether or not to renew their contracts, and generally must notify HCFA by July 1 if they are not going to renew.

19. Can HCFA make Medicare managed care plans continue their contracts to provide services to Medicare beneficiaries?

No. While HCFA is responsible for ensuring that managed care plans meet their contractual obligations, we cannot require them to stay in the Medicare program.

20. Some plans have increased their premiums and/or reduced their benefits. Why does HCFA allow plans to do this?

All Medicare managed care plans must offer the basic Medicare benefits. However, the law gives plans broad authority to offer supplemental benefits and to set premium and copayment levels. HCFA reviews the costs of all plan benefits to ensure that additional benefits are included, if necessary, and that beneficiary premium and cost sharing amounts fall within upper limits

permitted by law. As long as the premiums and cost sharing amounts remain under these limits, we have no authority to disapprove increases.

21. Will members of managed care plans leaving Medicare be able to keep prescription drug coverage, or is new coverage being made available?

If a member currently has prescription drug coverage through a managed care plan that is leaving Medicare, this coverage will end December 31, 2000. Members have the option to enroll in other managed care plans available in their area which may cover prescription drugs. However, the Medigap policies that must be made available to most members of a withdrawing managed care plan (policies "A", "B", "C" and "F") do not include prescription drug coverage. Medigap policies that contain prescription drug coverage are available, but insurers may refuse to sell a policy based on health status, may impose waiting periods for pre-existing conditions, and may charge you more based on these conditions.

Remember, if you had previous Medigap drug coverage (plans "H", "I", or "J"), and this was your first time in a Medicare managed care plan, and you leave the Medicare managed care plan within 12 months, you can go back to this policy if your old insurer still sells it. Also, if you joined your Medicare managed care plan within the past 12 months as your first choice when you became entitled to Medicare at age 65 and you disenroll from the Medicare managed care plan before the 12-month period has expired, you have the choice of all plans "A" through "J" that are available in your State. However, in either of these cases, you must apply for the Medigap policy within 63 days of the date your managed care coverage ends.

22. Will I be able to go to the same doctors I've been using?

If you return to the Original Medicare Plan, it is very likely you will be able to continue seeing the same doctors and other providers you have seen through your current managed care plan. Most physicians participate in the Original Medicare Plan. If you choose

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to enroll in a new managed care plan you may need to select a new primary care physician and begin using a new network of providers. Before making a decision, you should check with your doctor to see if he/she will be able to see you in whatever new arrangement you have chosen.

23. What if I am receiving other services at home which need to continue after December 31, 2000, when my managed care plan leaves Medicare? How can I receive assistance to make sure that I still get the care I need?

If you are currently receiving home health care, or are using medical equipment such as oxygen or wheelchairs, you need to call the phone number shown on your Medicare managed care plan identification card and ask for Utilization Management (UM). They will help you receive care under the Original Medicare Plan or under a new Medicare managed care option. If you select a new managed care plan, you should contact the new managed care plan as soon as possible and ask for the UM department. If you return to the Original Medicare Plan, you should tell your provider to bill Medicare directly after January 1, 2001.

24. Will the Original Medicare Plan offer to pay for my prescription drugs?

Under current law, the Original Medicare Plan does not cover outpatient prescription drugs except in a few cases, like certain cancer drugs. However, many Medicare managed care plans cover outpatient prescription drugs, up to certain limits. Check with the health plans you are considering to see if they cover prescription drugs. After September 15, 2000 you can find this information on the Medicare website, **www.medicare.gov**.

25. What if I have employer or union coverage?

If you join a Medicare managed care plan or private fee-for-service plan and also have employer or union coverage, you may, in some cases, still be able to use this coverage along with your Medicare health plan coverage. Talk to your benefits administrator about the rules that apply.

26.I have heard that some managed care plans are not accepting new members. Do managed care plans have to accept my enrollment?

No, managed care plans do not always have to accept new enrollments. Some managed care plans have approved limits on the number of beneficiaries they can enroll (called "capacity limits"). Once a plan has reached its capacity limit, it does not have to accept any new enrollments. Capacity limits apply to enrollments made during ALL election periods.

In addition, if a plan does not have an approved capacity limit, it can voluntarily close enrollment during all or part of the Open Enrollment Period (which is any month during the years 2000 and 2001). If a plan is voluntarily closed, it does not have to accept new enrollments, except for certain special situations. Special situations include:

- the Initial Coverage Election Period (this is the three-month period immediately before a beneficiary enrolls in both Medicare Part A and Part B);
- the November Annual Election Period; and
- Special Election Periods such as if a beneficiary permanently moves outside of a plan's service area; if a beneficiary's plan is leaving the Medicare program; and if a beneficiary is making an election through an employer group.

If you would like to join a new managed care plan, you should contact the new plan and ask if it is accepting new member enrollments or if it has a waiting list. If a managed care plan refuses to accept your enrollment, it must provide a written denial.

27.What is a "capacity limit"?

A "capacity limit" is an approved limit on the number of beneficiaries that a managed care plan can enroll. If a plan has an approved capacity limit, it does not have to accept any new enrollments. Capacity limits apply to enrollments made during ALL election periods: the Initial Coverage Election Period (this is the three-month period immediately before a beneficiary enrolls in both

Medicare Part A and Part B), the November Annual Election Period, and Special Election Periods.

If you would like to join a new managed care plan, you should contact the new plan and ask if it is accepting new member enrollments or if it has a waiting list. If a plan refuses to accept your enrollment, it must provide a written denial.

28.I am in my first 12 months of Medicare managed care and received a letter from my managed care plan that I have special Medigap rights. If I choose to disenroll from my plan and apply for a Medigap policy, how do I prove to the Medigap insurer that I have these special rights?

You should present a copy of the letter your managed care plan sent you as proof to the Medigap insurer that you have special rights to purchase a Medigap policy because you are in your first 12 months of managed care. If your name does not appear on the letter and a Medigap insurer questions whether this letter is really yours and not just a photo copy of someone else's letter, you should call your managed care plan and tell them that you need a new letter with your name on it. Your managed care plan should work with you to prove to the Medigap insurer that you are in your first 12 months of managed care and have special Medigap rights. This exchange of information can also be handled by telephone if both parties agree. If your managed care plan will not cooperate in assisting you, contact your HCFA Regional Office, which should be able to verify for the Medigap insurer that you have these special rights.

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